

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SM(E5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 18704 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10685

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Somerset		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Princess Anne		c. LENGTH OF STAY IN lb life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Massey		First Bozman	Middle Bozman
4. DATE OF DEATH Sept. 21 1875	Month Sept.	Day 21	Year 1875
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 28, 1875
9. AGE (In years last birthday) 85	10. IF UNDER 1 YEAR Months 85	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Thomas Bozman	14. MOTHER'S MAIDEN NAME Melissa Bozman		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO.	17. INFORMANT Brice Bozman, Monie, Md.	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Heart Disease			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b)			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>R. H. Johnson</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) R. H. Johnson, M.D.	DATE SIGNED 9/23/60		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/24/60	22c. NAME OF CEMETERY OR CREMATORIAL Oriole	22d. LOCATION (City, town, or county) (State) Oriole, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE <i>James Henning</i>	ADDRESS Princess Anne, Md.	24a. REC'D BY REGISTRAR DATE SEP 27 '60	24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kraus</i>

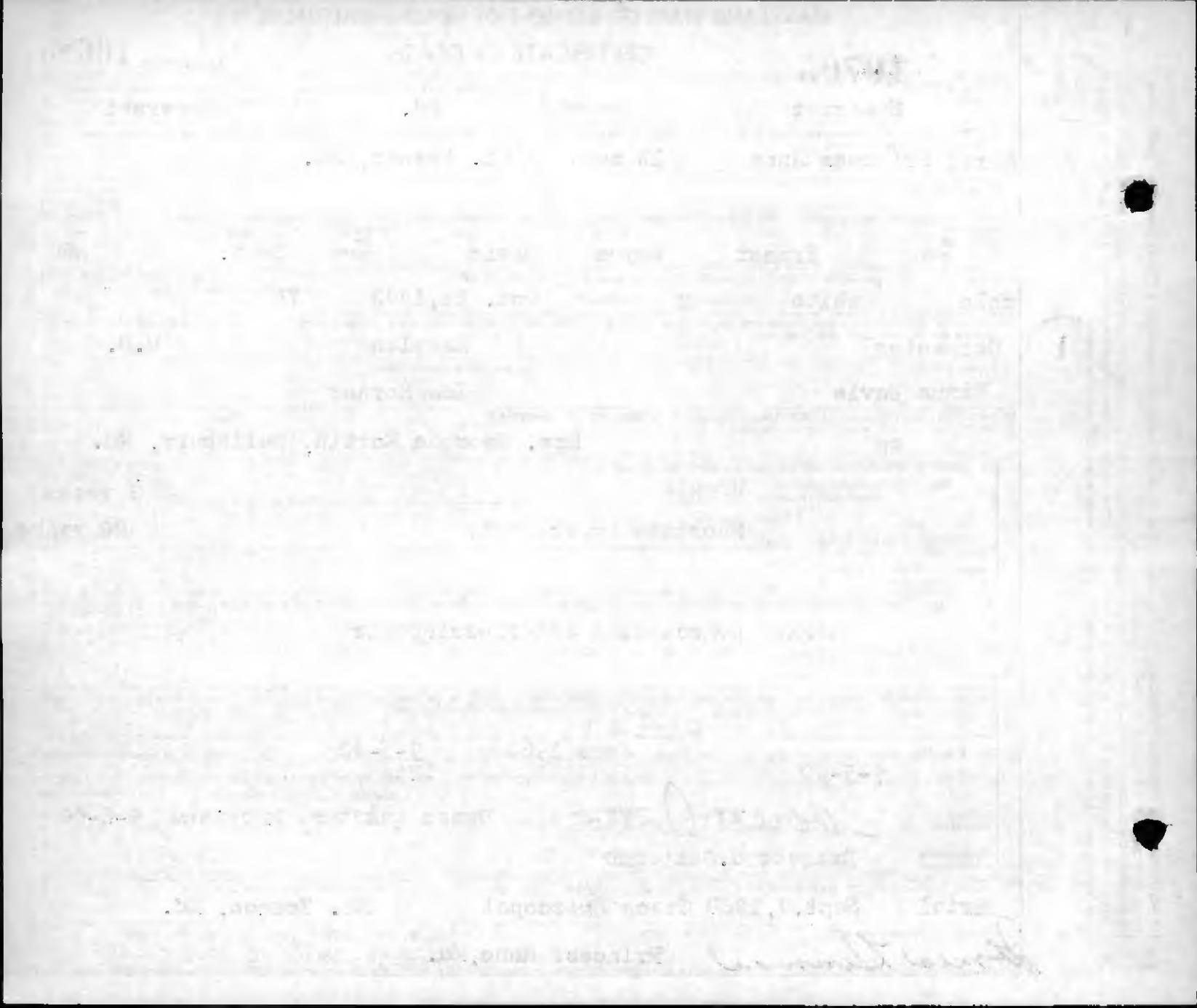
M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 10686

1. PLACE OF DEATH o. COUNTY Somerset		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Princess Anne		c. LENGTH OF STAY IN 1b 15 mon.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Vernon, Md.		
3. NAME OF DECEASED (Type or print) Ernest Wayne Davis		d. STREET ADDRESS 1		
4. DATE OF DEATH Sept. 5 1960	Month	Day	Year	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 24, 1883	
9. AGE (In years lost birthday) 76 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Minus Davis	14. MOTHER'S MAIDEN NAME Ida Horner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO.	INFORMANT Mrs. Georgia Martin, Salisbury, Md.	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 610X Uremia		INTERVAL BETWEEN ONSET AND DEATH 2 weeks		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Prostate hypertrophy (c)		20 years		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) marked generalized arteriosclerosis				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Dames Quarter, Maryland	(County) 9-6-60
21. I certify that I attended the deceased from June 1960 to 9-5-60 , 19 1960 , that I last saw the deceased alive on 9-5-60 , 19 1960 , and that death occurred at 12A M, from the causes and on the date stated above. ACTUAL SIGNATURE Everett C. Sutter PHYSICIAN'S NAME (Type) Everett C. Sutter MD				
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial	22b. DATE THEREOF Sept. 7, 1960	22c. NAME OF CEMETERY OR CREMATORIUM Grace Episcopal	22d. LOCATION (City, town, or county) Mt. Vernon, Md.	(State)
23. FUNERAL DIRECTOR'S SIGNATURE James Zimmerman	ADDRESS Princess Anne, Md.	24a. REC'D BY REGISTRAR SEP 9 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Krause	



TO HOSPITAL may be required by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

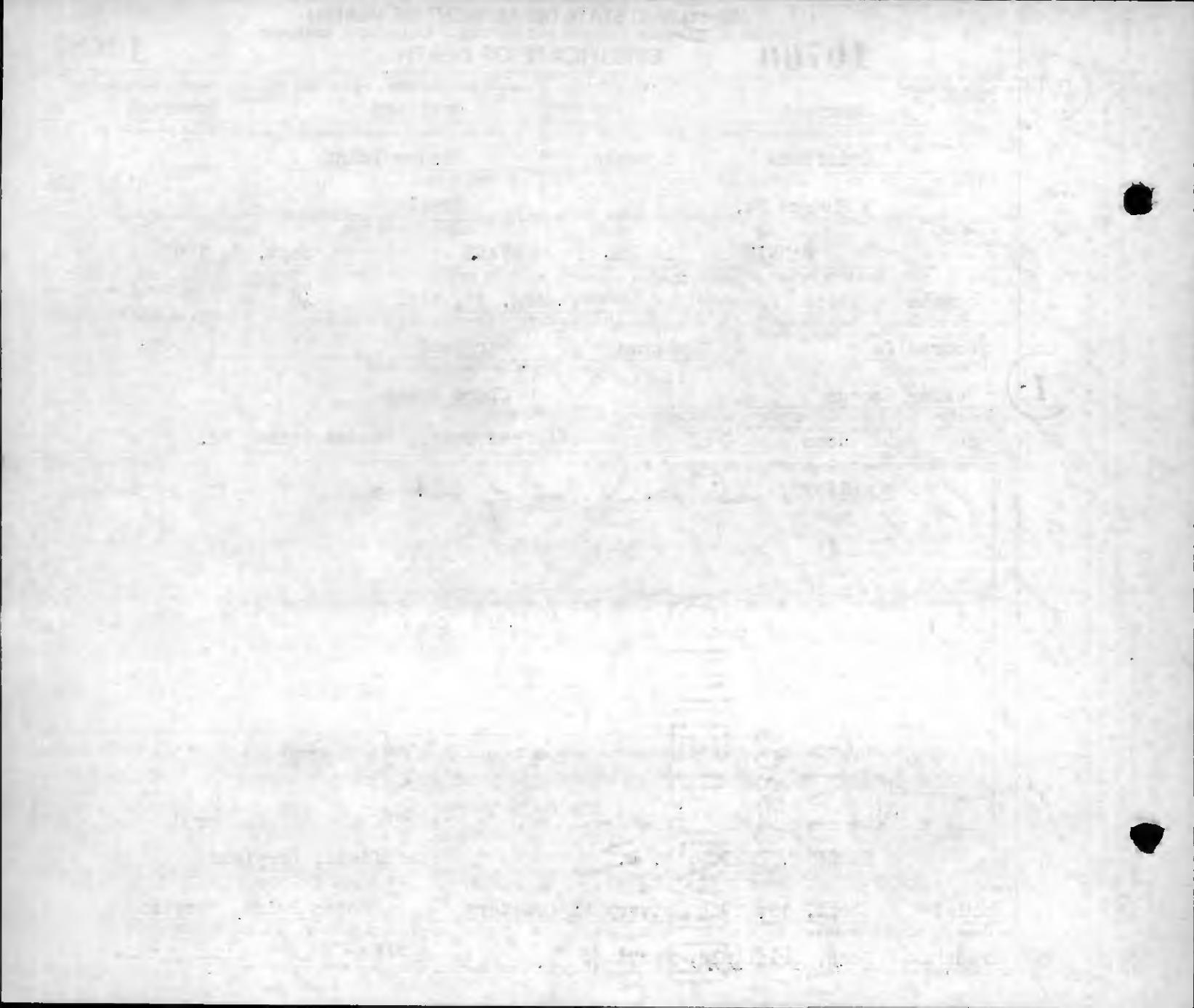
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10700

CERTIFICATE OF DEATH

10687

1. PLACE OF DEATH a. COUNTY Somerset		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield		c. LENGTH OF STAY IN 1b 2 weeks		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5 Hudson St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) NANNIE		First LOUISE	Middle EVANS	
4. DATE OF DEATH Sept. 9, 1960	Month	Day	Year 19	
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH Aug. 31, 1912	
8. ADDRESS Housewife	9. AGE (In years last birthday) 48 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Own home	11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
13. FATHER'S NAME Wesley Snaide	14. MOTHER'S MAIDEN NAME Clara Evans			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Winfred Evans, Rhodes Point, Md.	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 153.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)				
Carcinoma of Intestinal tract INTERVAL BETWEEN ONSET AND DEATH 6 mos.				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus - nephritis				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Crisfield	(County)	(State)	
21. I certify that (I) (this hospital) attended the deceased from January 1960 to Sept. 9, 1960 that (I) (we) last saw the deceased alive on Sept. 9, 1960 and that death occurred at 11:00 A.M. from the causes and on the date stated above.	22b. DATE SIGNED Sept. 14, 1960			
22c. PHYSICIAN'S NAME (Type) SARAH M. PEYTON, M. D.	M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS Crisfield, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Sept. 13, 1960	23c. NAME OF CEMETERY OR CREMATORIUM Calvary ME Cemetery	23d. LOCATION (City, town, or county) Rhodes Point, Maryland	(State)
24. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons, Crisfield, Maryland	ADDRESS	25a. REC'D BY REGISTRAR DATE SEP 16 '60	25b. REGISTRAR'S SIGNATURE Collins S. Thomas	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10688

Reg. Dist. No.

10706

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial; cremation, or removal.

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1. PLACE OF DEATH a. COUNTY Somerset			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairmount		c. LENGTH OF STAY IN 1b Lifetime		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairmount	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) At Home			e. STREET ADDRESS		
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First HERMAN	Middle WESLEY	Last FORD	4. DATE OF DEATH Month September Day 21 Year 19 60
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH October 6, 1884	9. AGE (In years last birthday) 75 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY Seafood		11. BIRTHPLACE (State or foreign country) Fairmount, Maryland	
13. FATHER'S NAME William S. Ford			14. MOTHER'S MAIDEN NAME Mary K. Ford		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Thomas Parks—Fairmount, Maryland Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Heart Disease</u> Sudden 420 INTERVAL BETWEEN ONSET AND DEATH Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Lie dead in yard</u> DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>R.H. Johnson</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED <i>Sept 21 - 1960</i>	
EXAMINER'S NAME (Type) <i>R.H. Johnson</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept. 23, 1960	22c. NAME OF CEMETERY OR CREMATORIUM Fairmount Cemetery	22d. LOCATION (City, town, or county) (State) Fairmount, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons—Crisfield, Maryland			ADDRESS	24a. REC'D BY REGISTRAR DATE SEP 26 '60	24b. REGISTRAR'S SIGNATURE <i>Carlton S. Keay</i>

DEPARTMENT OF HIGHER EDUCATION
EXAMINATIONS COUNCIL OF SOUTH AFRICA

1981

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

Item 10 Film 2619-29-60 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10703

10689

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Somerset	MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	b. COUNTY Somerset				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne	c. LENGTH OF STAY IN Tb 40 years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne	d. STREET ADDRESS				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) Elvyn Gordy Landing	First	Middle	Last	4. DATE OF DEATH Sept 1, 1960	Month	Doy	Year
5. SEX Male	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 8, 1912	9. AGE (in years from birthday) 47 yrs.	10. UNDER 1 YEAR Months Days Hours Min.	11. UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (State or foreign country) Pocomoke City, Md.	12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Eriece G. Landing	14. MOTHER'S MAIDEN NAME Ella Hancock						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO.	17. INFORMANT Mrs. Elvyn G. Landing, Princess Anne, Md.	Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422. / DUE TO Arteriosclerosis, generalized, Conditions, if any, which Myocardial hypertrophy, dilatation of gave rise to immediate cause (b) right atrium & ventricle, acute (c) stating the underlying cause first.				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Philip G. Insley Ph. G. A. Insley	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED 9-2-60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept. 3, 1960	22c. NAME OF CEMETERY OR CREMATORIUM St. Andrews Cemetery	22d. LOCATION (City, town, or county) Princess Anne, Md.	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Leroy R. Wilson, Princess Anne, Md.	ADDRESS	24a. REC'D BY REGISTRAR DATE SEP 6 '60	24b. REGISTRAR'S SIGNATURE Charles L. Thomas				

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10707 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10690

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Somerset		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Somerset		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Shelltown		c. LENGTH OF STAY IN 1b life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Shelltown		d. STREET ADDRESS ---		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ---				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First GARY	Middle CRAIG	Last MADDOX	4. DATE OF DEATH September 7, 1960	Month September	Day 7	Year 1960
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Oct. 2, 1957	9. AGE (In years less birthday) 2 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Frederick William Maddox				14. MOTHER'S MAIDEN NAME Grace Rose Price				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. No		17. INFORMANT Frederick W. Maddox, Shelltown, Maryland		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowned</u> DUE TO <u>Swims</u> 129.8 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fell in water near</u> DUE TO <u>Pocomoke River</u> (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell in water -</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year 3:30 p.m. 9-7 1960		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) water house		20f. (City or town) (County) (State) Pocomoke City, Marion County, Maryland		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <u>R. H. Johnson</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						DATE SIGNED Sept. 7-1960
EXAMINER'S NAME (Type) R. H. JOHNSON, M.D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-9-60		22c. NAME OF CEMETERY St. Paul's		22d. LOCATION (City, town, or county) Marion Station, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert H. Watson</u>		ADDRESS Pocomoke City, Md.		24a. REC'D BY REGISTRAR SEP 13 '60		24b. REGISTRAR'S SIGNATURE <u>Collins & Sons</u>		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

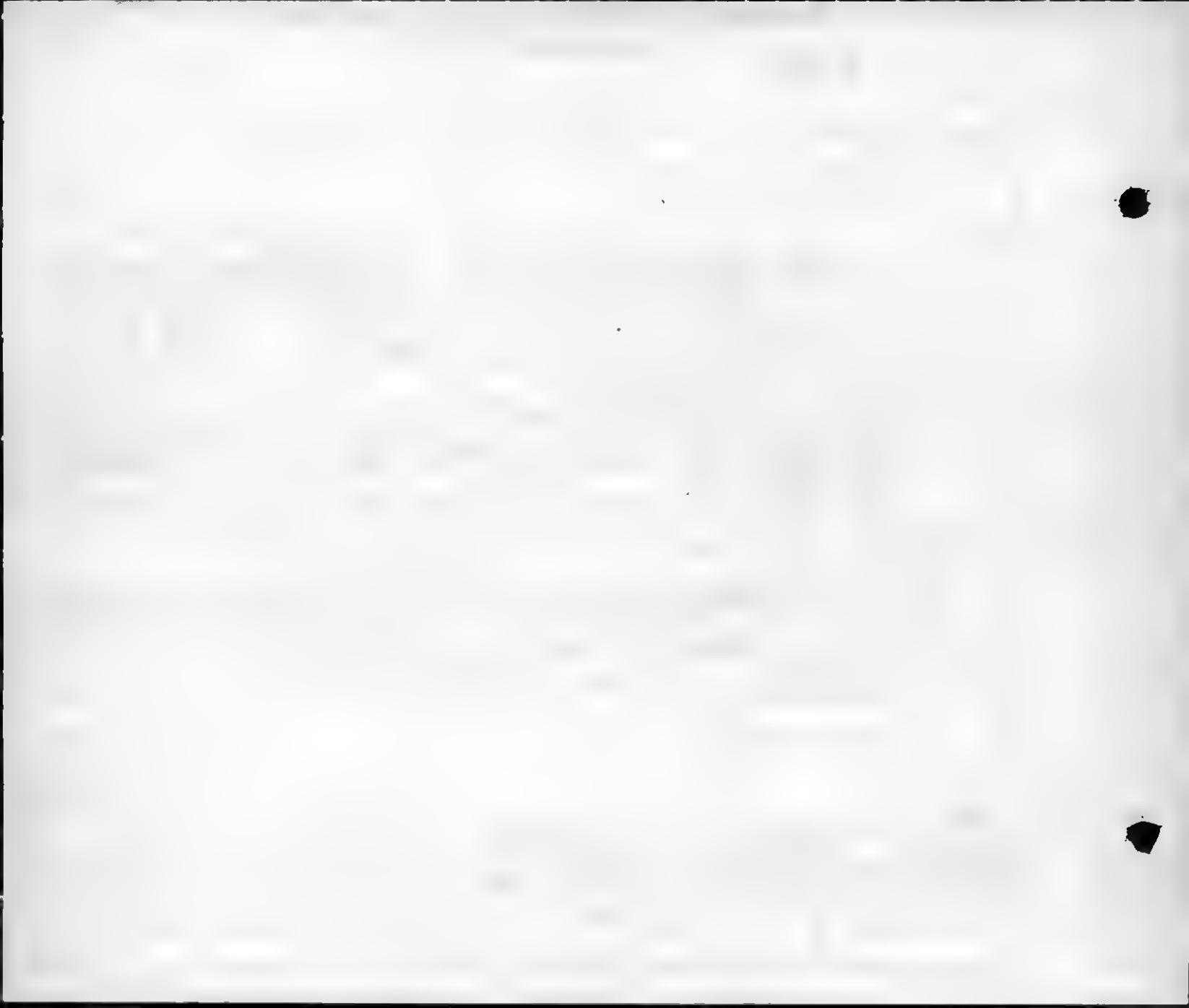
CERTIFICATE OF DEATH

Reg. Dist. No. 10691

1. PLACE OF DEATH a. COUNTY SOMERSET		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRISFIELD	c. LENGTH OF STAY IN 1b LIFETIME	b. COUNTY SOMERSET	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRISFIELD			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION AT HER HOME	d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) NAOMI	First NAOMI	Middle MASON	4. DATE OF DEATH SEPT 9 Month Day Year 1960			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 26 - 1875			
9. AGE (in years last birthday) 85 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEHOLD		10b. KIND OF BUSINESS OR INDUSTRY HOUSEHOLD	10c. BIRTHPLACE (State or foreign country) MARYLAND			
11. CITIZEN OF WHAT COUNTRY? U.S.A.		12. MOTHER'S MAIDEN NAME SARAH STERLING				
13. FATHER'S NAME AUGUSTUS STERLING		14. MOTHER'S MAIDEN NAME SARAH STERLING				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. UNKNOWN				
17. INFORMANT MRS ALLIE STERLING - CRISFIELD MD		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Urinary calculus - generalized DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Parkinson's Disease DUE TO (c)				
		INTERVAL BETWEEN ONSET AND DEATH 5 yrs.				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Parkinson's Disease						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 33 W. Mason - Crisfield MD	20f. (City or town) Crisfield	(County) Wicomico Co.	(State) MD.
21. I certify that I attended the deceased from Sept 9 , 1960, to Sept 9 , 1960, that I last saw the deceased alive on Sept 9 , 1960, and that death occurred at 7:15 AM , from the causes and on the date stated above.						
ACTUAL SIGNATURE Sarah M. Peyton				ADDRESS (Street, city or town, state) 33 W. Mason - Crisfield MD		
DATE SIGNED 7/15/60						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept 13-1960	22c. NAME OF CEMETERY OR CREMATORIUM ASBURY METHODIST	22d. LOCATION (City, town, or county) CRISFIELD		
23. FUNERAL DIRECTOR'S SIGNATURE L. Webster Crisfield MD		24a. ADDRESS 111 E. Main St.	24b. REC'D BY REGISTRAR SEP 15 '60	24b. REGISTRAR'S SIGNATURE L. Webster Crisfield MD		

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be relied on by the hospital or attending physician.

TO FUNERAL: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10708

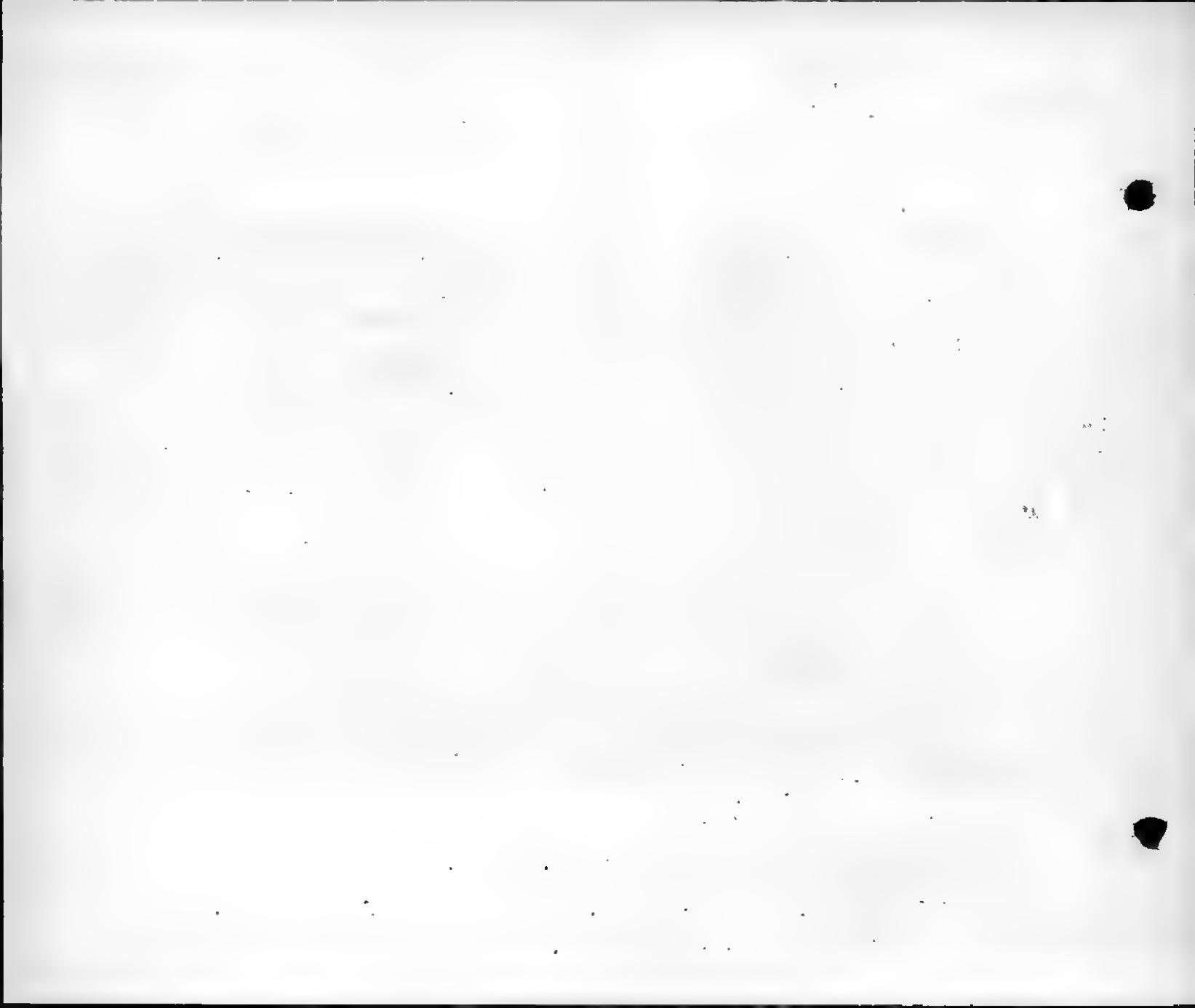
CERTIFICATE OF DEATH

Reg. Dist. No. 10692

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4
ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

1. PLACE OF DEATH a. COUNTY SOMERSET		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) b. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRISFIELD		c. LENGTH OF STAY IN 1b 5 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EDW. W. McCREADY MEMO. HOSP.		e. STREET ADDRESS RUMBLEY	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First ELIZABETH	Middle CAROL	Last MEREDITH
4. DATE OF DEATH	Month SEPTEMBER	Day 22	Year 1960
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 8, 1881
9. AGE (In years at first birthday) 79	10. IF UNDER 1 YEAR yrs 1	11. IF UNDER 24 HRS Months Days Hours Min 0 0 0 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME James Catlin		14. MOTHER'S MAIDEN NAME Elizabeth Ann Lankford	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	INFORMANT CAROL MEREDITH, RUMBLEY, MARYLAND	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Execute due to Haut Menus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 420.1 (b) Clonic myoclonic clonic convulsions (c) Coronary emboli			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c) General arterio sclerosis			
20c. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b) Sept 17, 1960	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Sept 17, 1960 , to Sept 22, 1960 that I last saw the deceased alive on SEPT. 22, 1960 , and that death occurred at 3:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE George C. Coulbourn		ADDRESS (Street, city or town, state) MARTON, MARYLAND	
PHYSICIAN'S NAME (Type) GEORGE C. COULBOURN, M.D.		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept. 25, 1960	22c. NAME OF CEMETERY OR CREMATORIUM Fairmount Cemetery	22d. LOCATION (City, town, or county) (State) Fairmount, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons—Crisfield, Md.		24a. REC'D BY REGISTRAR SEP 27 '60	24b. REGISTRAR'S SIGNATURE Charles J. Trahan



TO HOSPITAL by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8, 9, 11 Film 271 9-20-60 et

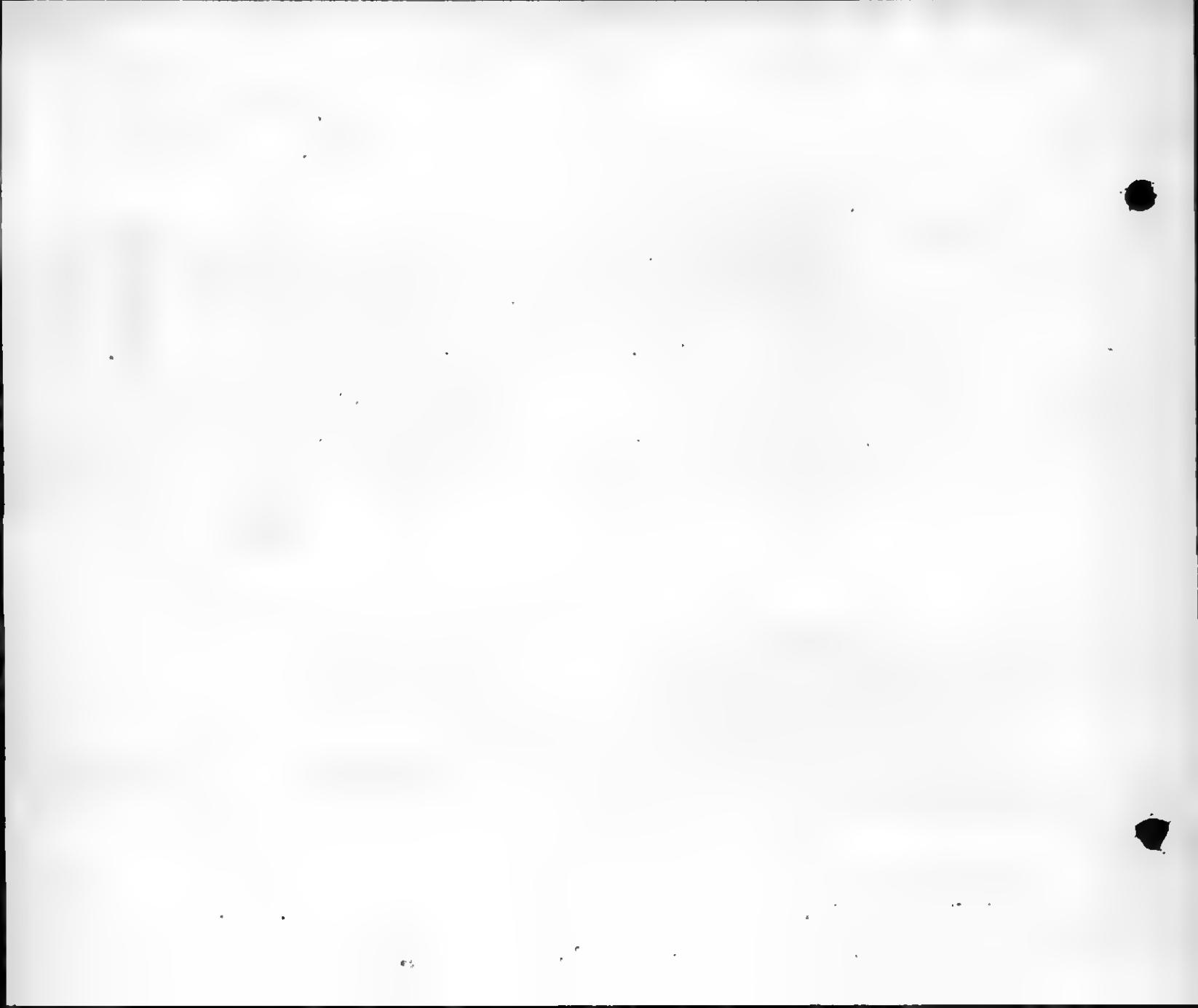
10709

CERTIFICATE OF DEATH

Reg. Dist. No.

10693

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE	
SOMERSET		MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
CRISFIELD	64 YEARS	CRISFIELD	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS		
EDW. W. McCREADY MEMORIAL HOSP.	1 MAIN STREET		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First JOHN	Middle L.	Last NELSON
4. DATE OF DEATH	Month SEPTEMBER	Day 3	Year 1960
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 11/8/96
MALE	WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years lost birthday) 63 01 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
RETIRED CONTRACTOR	ELECTRICAL WORK	MARYLAND	U.S.A.
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
JOHN B. NELSON	MARY R. L. STERLING		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES	16. SOCIAL SECURITY NO	INFORMANT	Address
WW I	224-20-0131	MRS. EVELYN NELSON, CRISFIELD, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis			
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)			
DUE TO			
(c)			
INTERVAL BETWEEN ONSET AND DEATH 3-4 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on 9/3/60, 19_____, and that death occurred at 1:17 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE	ADDRESS (Street, city or town, state) DATE SIGNED		
PHYSICIAN'S NAME (Type)	C. G. RAWLEY, M.D., MAIN STREET, CRISFIELD, MARYLAND		
22a. BURIAL, CREMAT. ON, REMOVAL (Specify) BURIAL	22b. DATE THEREOF SEPT. 6, 1960	22c. NAME OF CEMETERY OR CREMATORIUM SUNNYRIDGE CEMETERY	22d. LOCATION (City, town, or county) (State) CRISFIELD, MD.
23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS BRADSHAW & SONS—CRISFIELD, MD.	24a. REC'D BY REGISTRAR DATE SEP 13 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Krause



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 FilmG272 10-3-60 et

10710

CERTIFICATE OF DEATH

Reg. Dist. No.

10694

ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO HOSPITAL by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
SOMERSET		MARYLAND		a. STATE MARYLAND	b. COUNTY SOMERSET
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b RURAL and give nearest town) CRISFIELD		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTOVER	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EDW. W. McCREADY MEMO.HOSP.		23 DAYS		d. STREET ADDRESS Box 137 - RFD #1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First WILLIAM	Middle AUSTIN	Last RAGAN	4. DATE OF DEATH SEPTEMBER 23	Month Year 1960
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1869 Jan. 29, 1870	9. AGE (In years last birthday) 91 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min. 0 0 0 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Conowingo, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Alexander Ragan			14. MOTHER'S MAIDEN NAME unknown		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-16-7127		INFORMANT Mrs. Beulah Ragan--R.F.D. Westover, Md.	
Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Tope Myocarditis</i>					
DUE TO <i>artery & right side, Icaria vein & heart</i>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>and left, Gangrenous left foot</i>					
DUE TO <i>Arteritis - 2 months & Venous & Venosity</i>					
INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <i>Faster & right side. 2 months.</i>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A			
20c. TIME OF INJURY Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) MAIN STREET	(County) (State)
21. I certify that I attended the deceased from <i>july 20, 1960</i> to <i>July 23, 1960</i> that I last saw the deceased alive on <i>July 22, 1960</i> , and that death occurred at <i>3:50 p.m.</i> N/A from the causes and on the date stated above.					
ADDRESS (Street, city or town, state) DATE SIGNED <i>ADDRESS: Main Street, Crisfield, Maryland DATE: 7/23/60</i>					
ACTUAL SIGNATURE <i>A. N. Barr, M.D.</i>					
PHYSICIAN'S NAME (Type) A. N. BARR, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial					
22b. DATE THEREOF Sept. 25, 1960					
22c. NAME OF CEMETERY OR CREMATORIUM Rehobeth Presbyterian Cemetery					
22d. LOCATION (City, town, or county) Rehobeth, Md. (State)					
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons--Crisfield, Md.					
ADDRESS 24a. REC'D BY REGISTRAR DATE SEP 27 '60					
24b. REGISTRAR'S SIGNATURE <i>C. L. Barr</i>					



MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10695

10702

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Somerset		MARYLAND		2. USUAL RESIDENCE (Where deceased lived - If institution Residence before admission) a. STATE Maryland	
				b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield	
				c. LENGTH OF STAY IN Tb Life	
				d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield	
				e. STREET ADDRESS 30 Franklin Lane	
				f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First HENRY	Middle CHRISTOPHER	Last SOMERS	4. DATE OF DEATH Month September
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH March 8, 1877	Day Year 25, 1960
			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) 83 yrs	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY Seafood		11. BIRTHPLACE (State or foreign country) Crisfield, Maryland	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 213-10-7263		17. INFORMANT Address Mrs. Bocky Somers, Crisfield, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH 5 wks.			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		Fracture of femur 5 wks.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Patient fell in home			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. Aug. 18 1960		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
20f. (City or town) Crisfield		(County) Somerset		(State) Md.	
21. I certify that (I) (this hospital) attended the deceased from Aug 25, 1960 to Sep 25, 1960 , that (I) (we) last saw the deceased alive on Aug 24, 1960 , and that death occurred at 12 P.M. from the causes and on the date stated above.					
22a. SIGNATURE C. G. Rawley		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) C. G. RAWLEY, M. D.		22d. ADDRESS Crisfield, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept 28, 1960		23c. NAME OF CEMETERY OR CREMATORIAL Mariner's Cemetery	
23d. LOCATION (City, town, or county) Crisfield, Maryland		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons, Crisfield, Maryland		ADDRESS		25a. REC'D BY REGISTRAR DATE SEP 30 '60	
				25b. REGISTRAR'S SIGNATURE Arthur L. Kline	

TO HOSPITAL by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10696

10711

CERTIFICATE OF DEATH

Reg. Dist. No.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be read by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>SOMERSET</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MARYLAND</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WENONA</u>		c. LENGTH OF STAY IN 1b <u>LIFETIME</u>				
d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OR INSTITUTION <u>At His Home</u>		e. STREET ADDRESS <u>108 Main Road</u>				
3. NAME OF DECEASED (Type or print) <u>KALTON</u>		First <u>K</u>	Middle <u>A</u>			
4. DATE OF DEATH <u>SEPT 5</u>	Last <u>T</u>	Month <u>Sept</u>	Day <u>5</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 7-1888</u>			
WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. AGE (In years lost birthday) <u>71</u> yrs.	10. IF UNDER 1 YEAR Months <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Seafood</u>	10c. BIRTHPLACE (State or foreign country) <u>Maryland</u>			
11. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		12. MOTHER'S MAIDEN NAME <u>Emily Gibson</u>				
13. FATHER'S NAME <u>CALVIN TAWES</u>		14. MOTHER'S MAIDEN NAME <u>ELLA TAWES - (WENONA MD)</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT <u>Address</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u>						
DUE TO <u>Arteriosclerosis of kidneys</u>		years				
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <u>Arteriosclerosis of kidneys</u>						
DUE TO (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>St Pauls</u>	20f. (City or town) <u>Wenona</u>	(County) <u>Mo</u>	(State) <u>Mo</u>
21. I certify that I attended the deceased from <u>July</u> , 19 <u>55</u> , to <u>Sept 5</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Sept 5</u> , 19 <u>60</u> , and that death occurred at <u>2A</u> M, from the causes and on the date stated above. ACTUAL SIGNATURE <u>Everett C. Sutter</u> PHYSICIAN'S NAME (Type) <u>Everett C. Sutter MD</u>		ADDRESS (Street, city or town, state) <u>Dames Quarter, Maryland</u>		DATE SIGNED <u>Sept 5, 1960</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried Sept 7-1960</u>		22b. DATE THEREOF <u>Sept 7-1960</u>		22c. NAME OF CEMETERY <u>St Pauls</u>		22d. LOCATION (City, town, or county) <u>Wenona</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>D. J. Webster</u>		ADDRESS <u>Deal Island</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 13 '60</u>	24b. REGISTRAR'S SIGNATURE <u>S. Thorne</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10712

CERTIFICATE OF DEATH

Reg. Dist. No.

10697

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
<i>SOMERSET</i>				a. STATE <i>MARYLAND</i> b. COUNTY <i>SOMERSET</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>CHANCE</i>		c. LENGTH OF STAY IN Tb <i>LIFETIME</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>CHANCE</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>AT HOME</i>				d. STREET ADDRESS <i>MAIN ROAD</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>ARWILLA</i>		First	Middle	Last	4. DATE OF DEATH <i>SEPT 12 1960</i>
5. SEX <i>FEMALE</i>		6. COLOR OR RACE <i>NEGRO</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>FEB 7 - 1907</i>	9. AGE (in years lost birthday) <i>53 yrs.</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>LABORER</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>SEAFOOD</i>		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>					
13. FATHER'S NAME <i>OSCAR GALE - SR</i>		14. MOTHER'S MAIDEN NAME <i>TOMASHIA WRIGHT</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16. SOCIAL SECURITY NO. <i>UNKNOWN</i>		17. INFORMANT <i>ELMA WALLACE - CHANCE - MD.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i>		6 hours			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>Hypertension</i>					
(b) DUE TO <i>Hypertension</i>		2 months			
(c)					
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) <i>Baltimore</i> (State) <i>M.D.</i>	
21. I certify that I attended the deceased from <i>July 9th 1960</i> to <i>Sept 12 1960</i> , that I last saw the deceased alive on <i>Sept 9th 1960</i> , and that death occurred at <i>2:00 PM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>915.60</i> DATE SIGNED					
ACTUAL SIGNATURE <i>Eidon S. Markman M.D.</i>					
PHYSICIAN'S NAME (Type) <i>Eidon S. Markman Princess Anne, MD.</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial Sept 16-1960</i>		22b. DATE THEREOF <i>Sept 16-1960</i>		22c. NAME OF CEMETERY <i>ST. CHARLES METHODIST CHANCE - MD</i>	
22d. LOCATION (City, town, or county) <i>Chance - MD</i>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. S. Webster Deal Island Md.</i>		24a. REC'D BY REGISTRAR DATE <i>SEP 19 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Cathleen S. Kline</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be read by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

